EvalBrief: Systems of Care

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Findings on the Implementation of Systems of Care at 14 CMHS Grant Communities

The Comprehensive Community Mental Health Services for Children and Their Families Program was initiated in 1993 by the Center for Mental Health Services (CMHS) to promote the development of community-based systems of care for children with serious emotional disturbance and their families. Comprehensive evaluation of this Federal program has been underway since 1994.

An earlier analysis was performed using a cohort of nine grant communities that received initial funding in 1997 and completed their grant cycle in August 2003 (CMHS, 2003). This study builds on the earlier study and involves the 14 grant communities that initially received funding in 1998. The grant communities varied along several dimensions, including governmental auspices; size; and racial, ethnic, and cultural demographics.

This study examined existing data, including original and continuation applications, ORC Macro site visit reports, and CMHS site visit reports, to determine how well each of these "graduating communities" implemented a system of care.

Method

The project team consisted of eight researchers with experience using qualitative and quantitative evaluation measures, most of whom were program experts.

An analytic framework describing systems of care was developed specifically for this study, based on a conceptual model consisting of five domains: (a) *Planning and Implementation Processes,* (b) *Governance,* (c) *Management,* (d) *Service System Processes and Characteristics,* and (e) *Service*

Study Highlights

- ***The 14 grant communities that initially received funding in 1998 were studied to determine how well each community implemented a system of care.***
- ***Thirty-eight components across five domains were studied.***
- ***The majority of communities were found to have attained a modest level of implementation of system-of-care components.***
- ***Interorganizational issues proved to be the most difficult challenge to overcome in implementing systems change.***
- ***Stronger, more inclusive governance structures acting with the benefit of clear theories of change are needed to produce and sustain system-level change.***
- ***Achieving and sustaining broad-scale system change is a slow process, often requiring more than a 6-year period.***

Delivery Characteristics and Components. Each of these five domains is comprised of several components based upon specific system-of-care principles and general planning principles for a total of 38 components. Five-point rating scales were developed for each of the 38 components and anchored to the definition of a component. A rating of 5 meant that the information showed that the grant community clearly met the definition for a component.

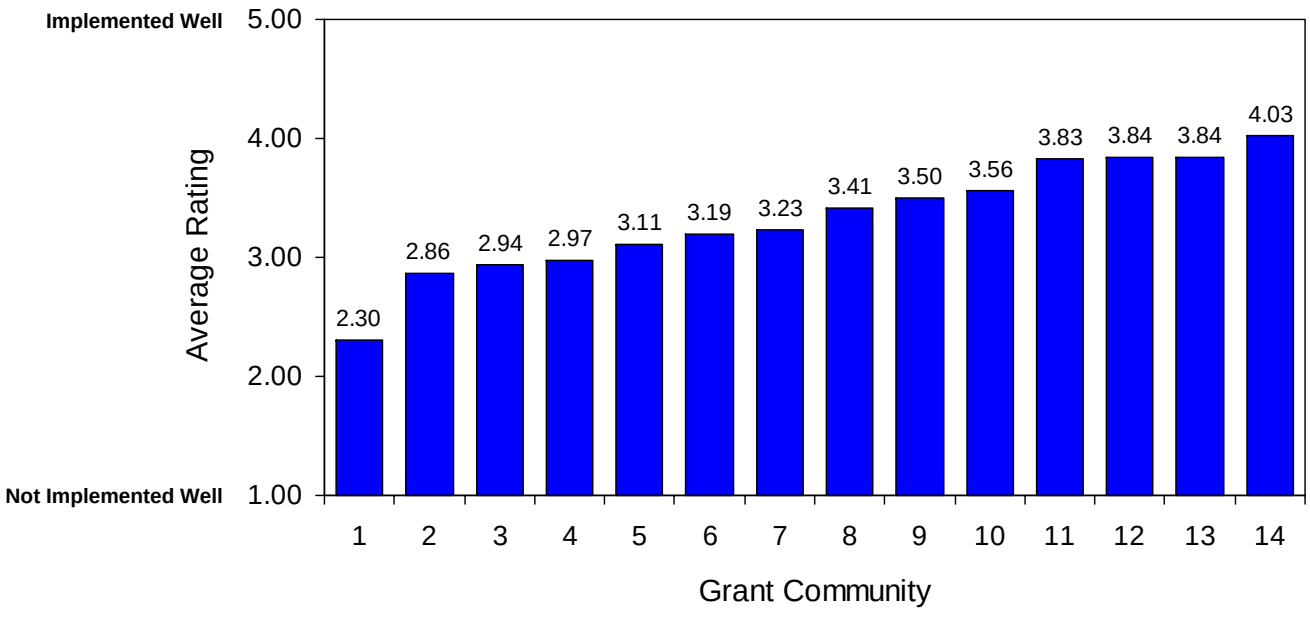
Findings

It was evident that there was no one best way to implement any of these factors. For example, an appropriate governance structure for a single county operation would not likely fit a multi-county project. What was important was whether, according to the documents that were reviewed, a grant community had developed a clear strategy for implementing the project based on a fit between the circumstances of the grant communities, an understanding of the advantages and disadvantages of the choices made, and strategies for addressing disadvantages explicitly through policies and practices.

Information on the degree of system-of-care implementation for the 14 graduating grant communities is summarized in Figure 1. This figure provides the average rating (5 = best) of the 38 system-of-care implementation factors. Only one of the grant communities achieved an overall high level (average rating of at least 4.0) of implementation of the defined system-of-care components. Four grant communities obtained average scores of less than 3.0, indicating poor implementation overall. The remaining nine grant communities obtained scores between 3.0 and 3.9, indicating a modest level of implementation of system-of-care components.

There was wide variation in how well the 38 components were implemented. For example, population defined, governance and funding partners defined, services provided to the whole family, family involvement in governance, care management structure, outreach, and services

Table 1
Average Implementation Rating on a 5-Point Rating Scale of 38 System-of-Care Components for 14 Graduating Grant Communities



provided in the least restrictive/most normal environment were all implemented very well (average ratings of 4.0 or higher).

With a few exceptions, the grant communities had well-defined structures that involved outreach to families and services to address strengths and needs in the whole family (not just the children), with the aim of providing services in the community and family homes, rather than in more restrictive settings.

Other system-of-care components were not implemented well. For example, "access to evidence-based practices and programs" achieved an average of 1.0 with all 14 of the grant communities rated as a 1, indicating that there was no use of evidence-based practices and programs in any of their systems of care.

System-of-care components that achieved the lowest ratings were access to evidence-based practices and programs, early identification and intervention of behavioral health problems, theory of change, and smooth transition to adulthood and independence. These are important dimensions of any service delivery system. The lack of any example of evidence-based practice may be due to the fact that when these grant communities began their work in 1998, there was less focus on evidence-based practices than there currently is (Hoagwood, 2002).

Lessons Learned

- Grant communities with a prior history in service integration and financing strategies had an advantage in implementing a system of care. However, in a system where a county or State has historically contracted with a small group of providers for many years, it is politically difficult to leverage substantial changes in the traditional service delivery pattern.

- Continuity of participants at the governance and service delivery levels was critical in achieving important collaboration and coordination goals. Similarly, the greatest barrier to continuity of care was staff turnover, a major problem in many communities.

- Another lesson was that an explicit infrastructure to support the diffusion of new practice principles and values was needed to impact the general practices of partner agencies. Without such structures, collaboration only involved the most active agencies and was, too often, further restricted to children and families enrolled in the system of care. Examples of specific structures or processes were found in the areas of cultural competence, family involvement, and service delivery.

  One State legislature created a mandate to create cultural competence consultants for each major ethnic minority group. Another system of care set up cultural resource centers for different ethnic groups.

  Family involvement at the governance level was facilitated by establishing separate family advocacy organizations and the use of family advocates for engaging families in the system of care.

  In the domain of service delivery, a few sites had agencies share forms and management information systems, which facilitated practitioners adopting new modes of behavior.

  The adoption of forms that guided practitioners into looking at all domains of the child and family's life was another strategy.

  However, only a few grant communities had implemented methods to secure information for improving direct service quality. Without such information, at both the system and client levels, there were few examples of strong continuous quality improvement systems that informed decision-making.

Conclusions

The findings indicated the 14 grant communities in this study made substantial progress in implementing service delivery processes consistent with system-of-care principles. However, implementing service delivery processes did not readily translate into implementing changes at system levels.

The findings of this study are very similar to those of Vinson et al. (2001) and Brannan et al. (2002). In many of these grant communities, the case manager was the major vehicle for services integration and collaboration, with little or no additional processes or structures to facilitate these activities. Most grant communities were well into the basic system-of-care implementation at the end of the grant period, but had not achieved an integrated system of care.

This study confirmed the findings of the initial cohort that the most difficult issues in implementing systems changes were interorganizational. While the amount of money granted to a community for a system of care was substantial, it was relatively small compared to the resources of systems needed as partners (e.g., the schools, child welfare, or juvenile justice).

Similarly, the small number of children enrolled would not have a significant impact on any of these larger systems. Developing incentives for these other agencies to cooperate proved to be difficult, and most grantees clearly would have benefited from assistance in developing strategies to create win-win situations and encourage other partners to become involved in systems change.

These findings suggest that stronger, more inclusive governance structures, acting with the benefit of clear theories of change, are needed to produce and sustain system-level change. Evaluation routines built into the system of care could provide immediate and useful feedback on system development to enhance systems change.

The findings indicate there was no "one best way" to organize a system of care. The most successful communities developed strategies and structures that fit the circumstances of their local communities. Overall, the results indicate that achieving and sustaining broad-scale system change is a slow process, often requiring more than a 6-year period.

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